

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

 PLACE OF DEATH
 County St Charles
 Township _____ or _____
 Village _____ or _____
 City St Charles (NO. 704 Lewis St.; _____ Ward)
 Registration District No. 757 File No. 2504
 Primary Registration District No. 3036 Registered No. 11

(If death occurred in a hospital or institution, give its NAME instead of street and number)

 FULL NAME Octavia Logan

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>Colored</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>	DATE OF DEATH <u>Jan 24th</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH _____, _____, 18 <u>60</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Viewed Remains</u> , 191 <u>2</u> , that I last saw h_____ alive on <u>Jan 24</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>4:10 a</u> m.	
AGE <u>52</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Probably Mitral Insufficiency</u> <u>92A Died Suddenly -</u> (Duration) <u>One</u> yrs. _____ mos. _____ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>W. Arnold</u> , Coroner M. D. <u>Jan 24</u> 191 <u>2</u> (Address) <u>St Charles Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Mississippi</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>Ewan Smith</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>South Carolina</u>		Where was disease contracted if not at place of death? _____	
	MAIDEN NAME OF MOTHER <u>Vinice Smith</u>		Former or usual residence _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Virginia</u>		PLACE OF BURIAL OR REMOVAL <u>City Cemetery</u> DATE OF BURIAL <u>Jan 26</u> , 191 <u>2</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ewan Brady</u> (ADDRESS) <u>St Charles Mo</u>			UNDERTAKER <u>H. Hallman</u> ADDRESS <u>St Charles Mo</u>	
Filed <u>Jan 24</u> , 191 <u>2</u> <u>Chas. H. Koanster</u> REGISTRAR				

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County St Charles
 Township _____
 or
 Village _____
 or
 City St Charles (NO. 704 Lewis)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH ✓

Registration District No. 95-7 File No. 2504
 Primary Registration District No. 3036 Registered No. 11
 St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Octavia Logan

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>B-</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH _____ (Month) (Day) (Year) <u>860</u>		
AGE <u>5-2</u> yrs. mos. ds. If LESS than 1 day, hrs. or min.		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 24, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1912,
_____,
 that I last saw him alive on Jan 24, 1912,
 and that death occurred, on the date stated above, at 4:00 p.m.

OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

The CAUSE OF DEATH* was as follows:
Probably nitral insufficiency - died suddenly
 (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE
 (City or town, State or foreign country) Mississippi

PARENTS	NAME OF FATHER <u>Iraul Smith</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>North Carolina</u>
	MAIDEN NAME OF MOTHER <u>Donk Brown</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Virginia</u>

Contributory (SECONDARY) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. G. Arnold - Coroner
Jan 24, 1912 (Address St Charles Mo)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Devin Pruitt
 (ADDRESS) St Charles Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted _____
 If not at place of death? _____
 Former or usual residence _____

Filed Nov 9, 1912 Chas. N. Kinnaman
 REGISTRAR

PLACE OF BURIAL OR REMOVAL City Cem. DATE OF BURIAL Jan 26, 1912
 UNDERTAKER H. C. Dallmeier ADDRESS St Charles Mo.

Original file, date JAN 24, 1912. All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)